**DME Patient Evaluation Form**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_**

**Side Right Left BiLat Part of Body\_\_\_\_\_\_\_\_\_\_\_\_ DX Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Injury \_\_\_\_\_\_\_\_\_\_ Date of Surgery\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_**

**CPM Knee CPM Other Than Knee Vascutherm Rental Days \_\_\_\_\_\_**

**Prescribing Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notes**

**Instructions**

**Verbal Written**

**Technician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**